STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525704	A. Building B. Wing	02/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Eden Rehab Suites and Green House Homes	3151 Eden CT Oshkosh, WI 54904

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0573 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Let each resident or the resident's legal representative access or purchase copies of all the resident's records. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview and resident representative interview and record review, the facility did not provide timely access to a medical record for 1 resident (R) (R1) of 3 sampled residents. R1 requested a copy of R1's medical record in writing on 1/20/26. As of 2/5/26, R1 had not received the requested records. Findings include: On 2/5/26 at 4:36 PM, Surveyor interviewed Director of Nursing (DON)-B who stated the facility does not have a policy for medical record requests but follows state and federal regulations. From 2/4/26 to 2/5/26, Surveyor reviewed R1's medical record. R1 was admitted to the facility on [DATE] and had diagnoses including acute and chronic respiratory failure with hypoxia and chronic obstructive pulmonary disease with (acute) exacerbation. R1's Minimum Data Set (MDS) assessment, dated 12/10/25, had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R1 had intact cognition. R1 was responsible for R1's healthcare decisions. R1 was discharged from the facility on 12/10/25. On 2/4/26 at 1:24 PM, Surveyor interviewed Family Member (FM)-J who stated R1 and FM-J submitted a request for R1's medical record to Nursing Home Administrator (NHA)-A via email on 1/20/26. FM-J stated email communication continued through 1/22/26 when R1 signed a formal request for medical records that was also sent via email to NHA-A. FM-J stated R1 and FM-J had not yet received the requested records. FM-J stated NHA-A's email response indicated the facility had up to 30 days to provide the medical records. On 2/4/26 at 3:32 PM, Surveyor interviewed Social Worker (SW)-F who was aware of R1's request for medical records. SW-F stated SW-F was uncertain of the timeframe to release records but thought the facility had 48 hours. On 2/4/26 at 3:42 PM, Surveyor interviewed NHA-A who showed Surveyor a paper copy of R1's medical record. NHA-A stated the facility was going to have a meeting to review the records on 2/4/26; however, the meeting was postponed until 2/6/26. NHA-A stated NHA-A was going to call R1 and let R1 know the medical records were ready to pick up after the meeting.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 525704	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/05/2026
NAME OF PROVIDER OR SUPPLIER Eden Rehab Suites and Green House Homes		STREET ADDRESS, CITY, STATE, ZIP CODE 3151 Eden CT Oshkosh, WI 54904	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview and record review, the facility did not notify Hospice in a timely manner of uncontrolled pain for 1 resident (R) (R2) of 5 sampled residents.R2 received Hospice services and complained of uncontrolled pain. The facility did not notify R2's Hospice agency so adequate pain relief could be provided.Findings include:From 2/4/26 to 2/5/26, Surveyor reviewed R2's medical record. R2 received Hospice services and was admitted to the facility on [DATE]. R2 had diagnoses including prostate cancer metastasized to the bone, right heel stage 4 pressure ulcer, osteomyelitis, cervical radiculopathy, chronic pain, peripheral neuropathy, and opioid dependence. R2's Minimum Data Set (MDS) assessment, dated 1/23/26, indicated a Brief Interview for Mental Status (BIMS) assessment was not completed. A Staff Assessment for Mental Status indicated R1's cognition was modified independent. R2's Power of Attorney for Healthcare (POAHC) was activated on 1/21/26. R2 was sent to the emergency room (ER) on 1/23/26 and passed away at the hospital on 1/31/26. On 2/4/26 at 3:06 PM, Surveyor interviewed Admissions Coordinator (AC)-E who stated AC-E was informed on 1/23/26 that R2 maxed out on pain medication but still complained of pain at level 10 out of 10. AC-E spoke to the hospital discharge planner and stated R2's refusal of care was a concern. R2 had also activated the call light overnight and yelled at the nurses at the nurses' station. AC-E stated AC-E called Hospice and notified R2's family on 1/23/26 that R2's pain was at a level 10 out of 10 and R2 was asking for more pain medication than the facility could provide. On 2/4/26 at 2:13 PM, Surveyor interviewed Hospice Director of Clinical Services (DCS)-G who stated DCS-G was informed on the morning of 1/23/26 by Nursing Home Administrator (NHA)-A and AC-E that the facility had maxed out on scheduled and as needed (PRN) pain medication for R2; however, R2's pain rating was still a 9-10 out of 10 and R2 was being sent to the ER. DCS-G stated R2 did not max out on pain medication and indicated R2's medications could have been increased or changed. DCS-G stated Hospice had not received any reports of uncontrolled pain prior to that day and was not notified of R2's verbally aggressive behavior or pain escalation before R2's pain became uncontrolled. On 2/5/26 at 11:11 AM, Surveyor interviewed Director of Nursing (DON)-B who stated Registered Nurse (RN)-I had provided all of the pain medication that R2 could have; however, R2's pain was still at a level 10 out of 10 and the medication was ineffective. DON-B stated RN-I notified the on-call provider and sent R2 to the ER for evaluation. When asked if Hospice was contacted prior to sending R2 to the ER, DON-B could not recall. DON-B stated if Hospice was notified and wanted to assess R2, they would have been allowed to do so. DON-B stated AC-E contacted R2's POAHC to ask if R2 should go to the hospital and R2's POAHC agreed. DON-B did not know if RN-I had spoken to R2's POAHC.On 2/5/26 at 1:49 PM, Surveyor interviewed RN-I who worked the 1/22/26 AM and PM shifts and the 1/23/26 AM shift. RN-I stated R2 was not physically or verbally aggressive on 1/22/26. RN-I stated R2 was impatient on 1/23/26 regarding call light response time although it had only been 1-2 minutes. RN-I stated R2 repeatedly complained of pain everywhere at a level 10 out of 10 and requested IV pain medication which the facility could not provide. When RN-I asked if R2 wanted to go to the hospital, R2 stated yes. RN-I stated RN-I told Director of Nursing (DON)-B that R2 wanted to go to the hospital but did not notify Hospice because R2's mind was made up. RN-I stated R2's POAHC was at the facility and was talking to Hospice when Emergency Medical Services (EMS) arrived. RN-I verified RN-I did not initially notify R2's POAHC.

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NAME OF PROVIDER OR SUPPLIER: Eden Rehab Suites and Green House Homes		STREET ADDRESS, CITY, STATE, ZIP CODE: 3151 Eden CT Oshkosh, WI 54904	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff and resident representative interview and record review, the facility did not ensure written bed-hold and transfer/discharge notices were provided to 2 residents (R) (R2 and R13) of 3 sampled residents. In addition, the facility did not ensure notices that were provided contained required information on appeal rights. R2 was transferred to the hospital on 1/23/26. Neither R2 or R2's activated Power of Attorney (POA) were provided with a written bed-hold or transfer/discharge notice. R13 was transferred to hospital on 2/1/26. R13's written bed-hold and transfer/discharge notice did not include information pertaining to appeal rights. Findings include: On 2/5/26 at 2:43 PM, Surveyor interviewed Director of Nursing (DON)-B who stated the facility's Bed-Hold for Hospitalization and Therapeutic Leave/Discharge form is also the facility's policy. DON-B confirmed the facility does not have a separate bed-hold or transfer/discharge policy. 1. From 2/4/26 to 2/5/26, Surveyor reviewed R2's medical record. R2 was admitted to the facility on [DATE]. R2 received Hospice services and had diagnoses including metastasized prostate cancer, stage 4 pressure ulcer to the right heel, opioid dependence, spinal stenosis, cervical region, and chronic pain. R2's Minimum Data Set (MDS) assessment, dated 1/23/26, indicated R2's Brief Interview for Mental Status (BIMS) score was not completed. A Staff Assessment for Mental Status indicated R2 had moderate cognitive impairment. R2 had an activated POA who assisted with healthcare decisions. R2's medical record indicated R2 was transferred to the hospital on 1/23/26, due to chronic pain and refusal of care. R2's medical record did not indicate R2 or R2's POA were provided with a written bed-hold or transfer/discharge notice. On 2/4/26 at 1:42 PM, Surveyor interviewed POA-C who stated prior to R2's transfer to the hospital on the morning of 1/23/26, POA-C and POA-D met with Admissions Coordinator (AC)-E who informed POA-C and POA-D that R2 was being kicked out of the facility due to R2's complaints of pain, behaviors, and refusal of cares. POA-C stated AC-E said R2 would not be allowed back to the facility because R2 was not fit to be there. POA-C verified POA-C did not receive a bed-hold or transfer/discharge notice for R2's hospital transfer. On 2/4/26 at 2:02 PM, Surveyor interviewed POA-D who confirmed a bed-hold and transfer/discharge notice was not provided or discussed with the facility. POA-D stated POA-D was informed by AC-E that R2 would not be allowed back to the facility because R2 had uncontrolled pain and was combative with staff. On 2/4/26 at 3:06 PM, Surveyor interviewed AC-E who confirmed AC-E met with POA-C and POA-D prior to R2's transfer to the hospital. AC-E confirmed that AC-E told POA-C and POA-D the transfer was due to R2's uncontrolled pain and refusal of care. AC-E verified that AC-E did not discuss a bed-hold or transfer/discharge notice with POA-C or POA-D and informed POA-C and POA-D that the facility would not accept R2 back. On 2/5/26 at 11:11 AM, Surveyor interviewed Director of Nursing (DON)-B who confirmed a bed-hold and transfer/discharge notice was not reviewed or provided to R2, POA-C, or POA-D because the facility would not be accepting R2 back. DON-B was not aware of the facility's responsibility to provide bed-hold and transfer/discharge notices to all residents who transfer to the hospital and that the notices must include the facility's requirement to permit residents to return and their appeal rights. 2. From 2/4/26 to 2/5/26, Surveyor reviewed R13's medical record. R13 was admitted to the facility on [DATE] and had diagnoses including acute on chronic combined systolic and diastolic congestive heart failure and aspiration pneumonia. R13's MDS assessment, dated 1/29/26, had a BIMS score of 13 out of 15 which indicated R13 had intact cognition. R13 was responsible for R13's healthcare decisions. R13's medical record indicated R13 was transferred to the hospital on 2/1/26. R13's signed Bed-Hold for Hospitalization and Therapeutic Leave/Discharge form did not contain appeal rights, including the name, address (mailing and email), and telephone (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Eden Rehab Suites and Green House Homes	3151 Eden CT Oshkosh, WI 54904

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	number of the entity which receives such requests, or information on how to obtain an appeal form and receive assistance with completing the form and submitting the appeal hearing request. On 2/5/26 at 11:11 AM, Surveyor interviewed DON-B who indicated DON-B was not aware bed-hold and transfer/discharge notices must include information on appeals rights. DON-B verified the facility's form did not include the required information.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview and record review, the facility did not provide the necessary respiratory care and services for 1 resident (R) (R3) of 5 sampled residents. Staff did not assess R3's lungs prior to set-up or after R3's self-administered nebulizer treatments. Findings include: The facility's Respiratory policy, dated 1/2025, indicates: .3. Nebulizer Administration: Nebulizer treatments are ordered by a Medical Doctor (MD). Equipment is set up in the room as ordered. Nebulizer medications are provided by (Pharmacy) and stored in the medication cart. Qualified nursing staff prepare equipment and medications as ordered. Prior to administration of nebulizer medications, nursing staff assesses the resident's pulse, oxygen saturation, and auscultate lung sounds. After administering nebulizer medication, nursing staff assess the resident's pulse, oxygen saturation, minutes of nebulizer use, and auscultate lung sounds. Staff monitor for any adverse side effects after administration. 4. Documentation and Reporting: Nursing staff use nursing judgement and nursing assessment skills when documenting. Respiratory nursing documentation includes: 1. Pre/post nebulizer treatment assessment. On 2/4/26, Surveyor reviewed R3's medical record. R3 was admitted to the facility on [DATE] and had diagnoses including acute and chronic respiratory failure with hypoxia, chronic obstructive pulmonary disease (COPD), acute pulmonary edema, and heart failure. R3's Minimum Data Set (MDS) assessment, dated 6/9/25, had a Brief Interview for Mental Status (BIMS) score of 13 out of 15 which indicated R3 had intact cognition. R3 had an activated Power of Attorney for Healthcare (POAHC). On 2/4/26, Surveyor reviewed R3's physician orders and Medication Administration Record (MAR) which contained the following orders: ~ Self-administer nebulizers and inhaler after nurse set-up three times daily for self-administration (dated 2/20/25) ~ Nebulizer: Assess prior to administering nebulizer treatment. Document lung sounds, pulse, and respirations every 6 hours for COPD. R3's MAR indicated all nebulizer treatments were provided; however, nebulizer assessments were not completed as ordered. On 2/4/26 at 4:49 PM, Surveyor interviewed Director of Nursing (DON)-B who indicated nebulizer assessments should be documented in the MAR. DON-B verified R3's nebulizer assessments were not consistently documented in R3's MAR.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff and resident interview and record review, the facility did not provide adequate pain relief for 1 resident (R) (R2) of 5 sampled residents. R2 received Hospice services and was admitted to the facility on [DATE]. R2 complained of pain at a level 10 out of 10 on 1/23/26 and had aggressive behavior. Without consulting Hospice, the facility notified an on-call provider, indicated they had administered all of R2's ordered pain medication, and wanted to send R2 to the emergency room (ER). Hospice indicated they could have assessed R2 prior to the transfer to see if R2's pain medications could have been increased or changed which might have prevented the transfer. In addition, R2 had an order for morphine sulfate which could have been administered on the morning of 1/23/26 prior to the transfer.Findings include:The facility's Pain Management policy, revised January 2026, indicates: The facility must ensure pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences .The facility will utilize a systematic approach for recognition, assessment, treatment and monitoring of pain. Recognition: 1. In order to help a resident attain or maintain his/her highest practicable level of physical, mental, and psychosocial well-being and to prevent or manage pain, the facility will: a. Recognize when the resident is experiencing pain and identify circumstances whe the pain can be anticipated. B. Evaluate the resident for pain and the cause(s) .when a significant change in condition or status occurs (e.g., change in behavior or mental status .or an exacerbation of pain). c. Manage or prevent pain, consistent with the comprehensive assessment and plan of care, current professional standards of practice, and the resident's goals and preferences. 2. Facility staff will observe for non-verbal indicators which may indicate the presence of pain. These indicators include but are not limited to: .e. Behaviors such as: resisting care, distressed pacing, irritability, depressed mood .i. Negative vocalizations (e.g., groaning, crying, whimpering, or screaming). Pain Assessment: 1. The facility will use a pain assessment tool, which is appropriate for the resident's cognitive status, to assist staff in consistent assessment of a resident's pain. 2. Based on professional standards of practice, an assessment or evaluation of pain .may necessitate gathering the following information .b. History of addiction, past and/or ongoing and related treatment for opioid use disorder (OUD) .h. Impact of pain on quality of life (e.g., sleeping, functioning, appetite, and mood) .j. The resident's goals for pain management and his/her satisfaction with the current level of pain control .Pain Management and Treatment: 1. Based upon the evaluation, the facility in collaboration with the attending physician/prescriber, other health care professionals, and the resident .will develop, implement, monitor, and revise as necessary interventions to prevent or manage each individual resident's pain .4. Factors influencing the choice of treatments include: b. The resident's current medical condition. c. The resident's current medications. d. The resident's desired level of relief .Available treatment options g.Resident's elected Hospice benefit .5. For residents with an addiction history or opioid use disorder, the facility should use strategies to relieve pain while also considering the OUD or addiction history .6. Non-pharmacological interventions .f. Reassess and adjust the medication dose to optimize the resident's pain relief while monitoring the effectiveness of the medication .i. Opioid treatment should be individualized for each resident with consideration by the prescriber of utilizing immediate-release opioids instead of extended-release and long-acting forms of opioids. j. Facility staff will notify the provider, if the resident's pain is not controlled by the current treatment regimen. From 2/4/26 to 2/5/26, Surveyor reviewed R2's medical record. R2 was admitted to the facility on [DATE]. R2 receied Hospice services and had diagnoses including (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Eden Rehab Suites and Green House Homes		STREET ADDRESS, CITY, STATE, ZIP CODE 3151 Eden CT Oshkosh, WI 54904	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	prostate cancer metastasized to the bone, right heel stage 4 pressure ulcer, osteomyelitis, cervical radiculopathy, chronic pain, peripheral neuropathy, and opioid dependence. R2's Minimum Data Set (MDS) assessment, dated 1/23/26, indicated a Brief Interview for Mental Status (BIMS) score was not completed. A Staff Assessment for Mental Status indicated R2 had moderate cognitive impairment. R2's Power of Attorney for Healthcare (POAHC) was activated on 1/21/26 and was responsible for assisting R2 with healthcare decisions. R2 was transferred to the emergency room (ER) on 1/23/26 and passed away at the hospital on 1/31/26. On 2/5/26 at 10:43 AM, Surveyor interviewed Certified Nursing Assistant (CNA)-K who provided care for R2 on the 1/23/26 AM shift. CNA-K stated R2 requested medication for gas or pain and was rude and demanding. When CNA-K returned to R2's room later, R2 was balled up and was non-verbal.On 2/5/26 at 12:08 PM, Surveyor interviewed CNA-L who provided care for R2 on the 1/23/26 AM shift. CNA-L stated CNA-L turned R2's call light off at approximately 6:45 AM and R2 said R2 was waiting for pain medication. CNA-L returned to get R2's breakfast order approximately 40 minutes later and was told R2 was still in pain and did not want breakfast. CNA-L stated R2 raised R2's voice due to the the pain and refused breakfast, an ice pack, and repositioning.On 2/4/26 at 2:13 PM, Surveyor interviewed Hospice Director of Clinical Services (DCS)-G who stated DCS-G was informed on the morning of 1/23/26 by Nursing Home Administrator (NHA)-A and Admissions Coordinator (AC)-E that the facility had maxed out on scheduled and as needed (PRN) pain medication for R2; however, R2's pain rating was still at a level 9-10 out of 10 and R2 was being sent to the ER. DCS-G stated R2 did not max out on pain medication and indicated R2's medications could have been increased or changed. DCS-G stated Hospice was not given the opportunity to complete an assessment and adjust R2's pain medication. DCS-G offered to notify the Hospice Medical Director to increase R2's pain medication and to send a nurse to the facility to address pain management; however, the facility declined and stated they were sending R2 to the ER. DCS-G stated R2's hospitalization would not have been necessary had the facility involved Hospice in managing R2's pain. DCS-G stated the Hospice Hospital Liason met with R2 and R2's family in the ER and contacted the Hospice Medical Director who ordered Dilaudid 1 milligram (mg) intravenous (IV) x 2; however, R2 still had no relief. R2 was then given dexamethasone IV and lorazepam 1 mg IV and was still squirmish in pain. DCS-G stated R2 reported pain everywhere but it was worse in the abdomen and chest. R2 was admitted to the hospital on [DATE] and remained in the hospital until R2 passed away on 1/31/26.On 2/4/26 at 3:06 PM, Surveyor interviewed AC-E who stated AC-E was informed on 1/23/26 that R2 had maxed out on pain medication but still complained of pain at level 10 out of 10. AC-E spoke to the hospital discharge planner and stated R2's refusal of care was a concern. R2 had also activated the call light overnight and yelled at the nurses at the nurses' station. AC-E stated AC-E called R2's Hospice agency and notified R2's family on 1/23/26 that R2's pain was at a level 10 out of 10 and R2 was asking for more pain medication than the facility could provide. AC-E stated AC-E also informed R2's family about R2's refusals of cares and assessments. On 2/5/26 at 11:11 AM, Surveyor interviewed Director of Nursing (DON)-B who stated DON-B attempted assess R2 on the day of admission [DATE]) and the morning of 1/23/26; however, R2 refused and stated R2's pain was at a level 10 out of 10. DON-B stated Registered Nurse (RN)-I had provided all of the pain medication that R2 could have; however, R2's pain was still at a level 10 out of 10 and the medication was ineffective. DON-B stated RN-I discussed the matter with the Interdisciplinary Team (IDT) and notified the on-call provider. R2 was sent to the ER for evaluation of intractable and uncontrolled pain. When asked if Hospice was contacted prior to sending R2 to the ER, DON-B could not recall. DON-B stated if Hospice was notified and wanted to assess R2, they would have been allowed to do so. DON-B stated the expectation is that Hospice evaluate before a resident is sent out. (continued on next page)

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For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	DON-B stated the increase in R2's behavior was due to a progression of pain over time. DON-B stated AC-E contacted R2's POAHC to ask if R2 should go to the hospital to which R2's POAHC agreed. DON-B did not know if RN-I had spoken to R2's POAHC but indicated RN-I should have done so. Surveyor reviewed R2's Medication Administration Record (MAR) with DON-B who confirmed R2 could have received more PRN morphine since R2 was not transferred to ER on [DATE] until 12:45 PM. DON-B stated DON-B trusted RN-I that all medications that could be given were given.R2's MAR contained the following orders:~ Morphine sulfate oral tablet 30 milligrams (mg) 1 tablet every 12 hours for pain/shortness of breath (SOB). (The medication was administered on 1/22/26 at 8:00 PM and 1/23/26 at 8:00 AM.) ~ Morphine sulfate oral solution 10 mg/5 milliliters (ml) Give 2.5 ml every 2 hours PRN for chronic pain x 3 days. (The medication was not administered on 1/22/26. The medication was administered on 1/23/26 at 7:01 AM in addition to non-pharmacological interventions of distraction and repositioning.) ~ Lyrica (pregabalin) oral capsule 75 mg Give 2 capsules three times daily. (The medication was administered on 1/22/26 at bedtime (HS) and 1/23/26 in the AM.) (Of note: R2 did not receive PRN Tylenol or lorazepam on 1/22/26 or 1/23/26.) ~ Pain Monitoring - Assess for pain monitoring for 3 days (dated 1/22/26). (R2's pain level on the 1/22/26-1/23/26 night shift was documeted as 0; R2's pain level on the 1/23/26 AM shift was documented as 10.)On 2/5/26 at 1:49 PM, Surveyor interviewed RN-I who worked the 1/22/26 AM and PM shifts and the 1/23/26 AM shift. RN-I stated R2 was not physically or verbally aggressive on the 1/22/26 AM shift. RN-I stated R2 was impatient on 1/23/26 regarding call light response time although it had only been 1-2 minutes. RN-I stated R2 repeatedly complained of pain everywhere at a level 10 out of 10 and requested IV pain medication which the facility could not provide. RN-I stated R2 received scheduled morphine and PRN morphine close to the same time. RN-I stated R2 said R2 used to take 6 Oxy per day and the pain was not going to be controlled by RN-I. RN-I opted to administer morphine because R2 was aggressive in conversation and jerked toward RN-I like R2 was going to jump on RN-I. R2 insisted the morphine would not work and requested 6 Oxy tablets or IV pain medication. When Surveyor asked why RN-I documented the morphine solution as effective, RN-I stated the morphine was effective even though R2 was aggressive. When RN-I asked if R2 wanted to go to the hospital, R2 stated yes. RN-I stated RN-I offtered R2 PRN morphine again at approximately 9:00 AM but R2 refused. (Of note: R2's medical record did not indicate PRN morphine was offered and refused). RN-I stated RN-I told DON-B that R2 wanted to go to the hospital and R2's mind was made up. RN-I denied that RN-I said R2 was given the maximum amount of pain medication. RN-I stated R2's POAHC was at the facility and was talking to Hospice when Emergency Medical Services (EMS) arrived.On 2/5/26 at 2:33 PM, Surveyor interviewed Hospital Case Manager (HCM)-H who stated the facility called HCM-H on 1/22/26 before R2 went to the ER and stated they were sending R2 back due to pain control and behavior concerns. HCM-H stated HCM-H received a message from the Hospice Hospital Liason who indicated the facility was offered solutions but declined to give R2 more pain medication and sent R2 to the ER. On 2/5/26 at 3:40 PM, Surveyor interviewed DON-B who confirmed that R2's medical record did not indicate R2 was offered PRN morphine after 7:01 AM on 1/23/26. DON-B stated if PRN morphine was offered and refused, it should have been documented in R2's medical record.